

EXHIBIT 5



SURGICAL DICTATION

NAME: Watson, Michael
SURGEON: Andrew B Stein, MD
ASSISTANTS: Timothy B McConnell, MD
ANESTHESIA: General anesthesia
PREOPERATIVE DIAGNOSIS:

DATE: 12/06/2001
RECORD #: 2870428

Laceration of left leg with laceration of the deep and superficial peroneal nerves

POSTOPERATIVE DIAGNOSIS: Laceration of left leg with laceration of the deep and superficial peroneal nerves

TITLE OF OPERATION: 1) Repair of deep peroneal nerve, left leg 2) Repair of superficial peroneal nerve, left leg 3) Use of the operating microscope for repair

ESTIMATED BLOOD LOSS: Minimal

COMPLICATIONS: None

INDICATIONS: The patient is a 31-year-old male laborer who had a deep laceration sustained to the left lower extremity when he slipped while using a hand held circular saw. He was seen in the emergency room on December 5, 2001, where he was noted to have a deep laceration inferior to the neck of the fibula and was noted to have loss of sensation to both the deep and superficial peroneal nerve distribution. He also had no motor function to any of the muscles supplied by either nerve in the left lower extremity. The presumptive diagnosis was injury to the common peroneal nerve was made and was sutured. The patient was admitted for repair in the OR the following day. He understood the potential risks, benefits and alternatives to the surgery as well as the chance that he would not gain any useful recovery of the nerve, even with a technically satisfactory repair. He was, therefore, admitted and brought to the OR the following day.

PROCEDURE: After general anesthesia was administered, he was placed on the OR table in the right lateral decubitus position with the left lower extremity facing up. The left lower extremity was then prepped and draped in the usual sterile fashion. There was noted to be a 4 cm oblique laceration through the soft tissues, just inferior to the neck of the fibula. After the leg was exsanguinated with an Esmarch bandage, the tourniquet was inflated to 250 mmHg. This laceration was extended proximally and distally with a 15 blade and in appropriate fashion. Skin flaps were developed and retracted with retraction sutures. There were noted to be deep lacerations through the fascia overlying the biceps femoris muscle as well as an injury to the fascia overlying the peroneus longus muscle proximally. The common peroneal nerve was identified above the fibular head, posterior to the biceps and traced distally toward the region of the laceration through the muscle. The trifurcation of the peroneal nerve into the superficial and deep peroneal branches as well as the sensory branch was identified approximately 2 cm below his trifurcation. There was noted to be complete laceration through all three nerve branches. Loupe magnification was used for the initial dissection to be lined up with proximal and distal stumps of the three nerve branches and the operating microscope was then brought in for closer inspection and repair. Attention was first directed to the deep peroneal nerve branch. Both the proximal and distal stumps were cut back to healthy appearing fascicles with an 11 blade and using a tongue blade for support. Interrupted 8-0 nylon sutures were then used to repair the nerve using epineurial sutures only. The nerve was lined up using external landmarks as well as fascicular grouping to ensure proper orientation. With the knee flexed, it was possible to complete the repair with no tension at the repair site and it was felt that an excellent repair had been obtained using the microscope with no bulging of fascicles at the repair site and had good orientation as noted above.

At this point our attention was directed to the superficial peroneal nerve branch. Once again the proximal and distal stumps were cut back with an 11 blade to healthy appearing fascicles, removing approximately 1-2 mm of the ragged ends of the nerves. Interrupted 8-0 nylon sutures were again used to perform an epineurial repair, utilizing the external

RE: Watson, Michael

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landmarks of the nerve as well as the fascicular grouping to ensure proper orientation. Once again, excellent repair was obtained with no bulging of fascicles at the repair site and no pinching at the repair site either. At this point, inspection of the repaired nerves using the scope with flipping the nerves to inspect and observe circumferentially, revealed what was felt to be an excellent repair of both nerves. The sensory branch to the nerve which had been cut as noted previously was inspected. The distal stump of this nerve branch was quite ragged in appearance and when the nerve was cut back to what appeared to be healthy appearing fascicles, it was felt that the gap between the proximal and distal stumps was too great to afford a repair. Consequently the proximal stump of the sensory branch was buried in the muscle belly of the biceps femoris muscle to help prevent formation of a painful neuroma in this region. At this time, the tourniquet on the leg was deflated and hemostasis was obtained with pressure and the electrocautery. The wound was irrigated out with copious amounts of irrigating solution and the final inspection of the repaired nerve revealed once again, no change in the patient or the appearance of the repair site. At this time, the skin was reapproximated with interrupted 3-0 Vicryl sutures in the subcutaneous tissues and skin staples were used to reapproximate the skin. Sterile dressings were now applied as was a long-leg fiberglass cast, keeping the knee at 45 degrees of flexion and the ankle in the neutral position. The patient was then returned to a supine position and reversed from anesthesia and transferred out of the OR, having tolerated the procedure well.

Postoperatively, the cast be kept in place for four weeks postoperatively to take tension off the nerve repair site. The patient will then be allowed to gently work on regaining full knee extension. He will also be treated with an AFO until there is evidence of nerve recovery in the future.

Signed by

Andrew B Stein, MD 12/11/2001 13:00

Andrew B Stein, MD

DD: 12/06/2001 DT: 12/07/2001 JOB: 000093486

cc: